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Evaluation of the Vale of Glamorgan Dispersed Housing Scheme

Final Report

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.

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Evaluation of the Vale of Glamorgan Dispersed Housing Scheme

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Glossary

Acronym/Key word	Definition
DHS	Dispersed Housing Scheme
ESVG	Effective Services for Vulnerable Groups

1. Introduction and background

Introduction

1.1 This report describes the findings of an evaluation of the Vale of Glamorgan Dispersed Housing Scheme for people with severe and enduring mental health needs. The short evaluation of the Dispersed Housing Scheme (DHS) was commissioned by the Welsh Government's Effective Services for Vulnerable Groups Board (ESVG[1]) as it was identified as a project that takes action relating to recommendation 4(b) of the Welsh Government's 'Prevention Through Early Intervention: Helping people with mental health problems to find and keep a home' report (ESVG, 2014).

"Recommendation 4(b): There should be a pilot project to inform the "top-up" of Supporting People services by Local Health Boards. We highly commend those few examples where health monies have been accessed to 'top up' Supporting People services. We suggest that the Welsh Government considers setting up a regional pilot to test the feasibility of extending this collaborative and cost-effective approach. Where procurement practices are indicated to be a barrier, we further recommend greater use of collaborative frameworks for commissioning these services. " (Welsh Government, 2014)

1.2 The Vale of Glamorgan Mental Health DHS represents a unique collaboration between Housing, Support and Mental Health Services. It consists of a multi-agency group focussed on agreeing a service model appropriate to the needs of those with mental health problems in the Vale of Glamorgan. Agreement was reached in August 2013 and the existing scheme was remodelled to introduce an integrated dispersed supported housing scheme, comprising Housing Related Support and Specialist Rehabilitation provided by Qualified Nursing

[1] ESVG is focused on developing new ways of delivering public services, which have the potential to make a difference to peoples' lives at the same time as making better use of public money. It has an explicit focus on services which support the most vulnerable people in our society, and aims to improve the effectiveness and efficiency of public services for these groups by identifying, promoting and supporting the development of successful collaborative approaches.

Staff provided by Cardiff and Vale University Health Board. This hybrid model of support enables service users with mental health problems to take up their own tenancy with a fully integrated Care and Treatment Plan. The project went live with its first tenant signed up in March 2014. The core membership of the multi-agency group has now become a project steering group with representatives of the four organisations playing a role.

1.3 The Internal Research Programme within the Social Research Division, Knowledge and Analytical Services, was commissioned to undertake the Welsh Government evaluation. The remit of the internal research programme is to provide research support across policy areas and develop and deliver small-scale research projects. This report presents the background to and context for the DHS and the results of the evaluation.

Background

1.4 In November 2010, the Wales Audit Office (WAO) published a report on housing services for adults with mental health needs. The report noted that mental illness is common and disabling. It went on to emphasise the importance of access to housing of an appropriate quality and related care and support services being critical to people's independence and to social inclusion. The report further noted that a lack of secure housing is one of the key factors that can exacerbate and perpetuate social exclusion and risky behaviour, and can precipitate a move on to more institutional forms of care and support. The WAO report concluded weaknesses existed in the information used to plan and commission supported housing services and that there is a lack of effectiveness in joint planning of housing and supported housing services. The study found that vulnerable people with mental health problems faced difficulties accessing and maintaining social housing and concluded that the scale and extent of the housing difficulties experienced by them is not known (WAO, 2010).

1.5 Mental health problems can make it more difficult for people to find appropriate housing. For some sustaining tenancies can be problematic particularly when their health is deteriorating (Cabinet Office, 2010). People with mental health problems may have difficulty claiming benefits leading to debt and rent arrears. Social housing providers and landlords may have little or no awareness of mental health related issues and this can lead to problems with tenancies (Caffel, 2013).

1.6 People with mental ill health are more likely to live in rented accommodation than to own a property, are twice as likely to be unhappy with their housing than those without mental health issues and (Department of Health, 2007) and experience greater uncertainty in how long they can remain in their own home (Cabinet Office, 2010). Housing problems are often a reason for admission or readmission to mental health inpatient care (Department of Health, 2007). Lack of appropriate accommodation is a major reason for delays in discharging people back in to the community (Johnson & Griffiths, 2006). To manage and improve the situation there needs to be an integrated response across health, housing, social care and other partners (Caffel, 2013). Integration may lead to more effective and efficient service delivery that is based on the needs of individuals. The primary purpose of delivering integrated care is to improve the quality of care, improve the client experience and increase the cost effectiveness of care (Carnes Chichlowska *et al*., 2013).

1.7 In January 2015 a commission was set up by the Royal College of Psychiatrists to review the provision of acute inpatient care for adults in England. Responses to the Commission's Call for Evidence suggested that:

- If people are admitted for longer than clinically necessary they can become institutionalised, finding it harder to resume normal life (including loss or difficulty of finding work, benefits and a place to live).

- Recovery and rehabilitation need to occur as close as possible to where people live – for example, training people in 'activities of daily living' while in acute inpatient settings does not adequately equip them to use these skills in the community.
- Costs are often far higher in hospital.

1.8 Commissioners were also told that significant numbers of patients were admitted because of a lack of alternatives and that many had their discharges delayed. The Commission undertook an England-wide survey of consultants in charge of adult acute wards in order to understand the problem better. This survey revealed that many patients being treated on acute adult wards could have been treated elsewhere, and that there were major difficulties in discharging patients when they were ready to leave. The most commonly identified alternative services which were unavailable were crisis houses, rehabilitation services, personality disorder services, day services, and general community provision.

1.9 Several different reasons were given for these levels of delayed discharge, although a lack of suitable housing (ranging from local authority housing to supported accommodation) appeared to be a fundamental driver. The main factors affecting pressures on beds were availability of housing (39%) and quality/resourcing of community teams (30%). Patients were often placed in a more highly intensive and expensive care setting than they needed to be. The Commission's survey of acute wards revealed the critical importance of housing in the care of people with mental illnesses.

1.10 A project was commissioned by the Effective Services for Vulnerable Groups Delivery Board (ESVG, Welsh Government) in 2013 to explore integration between health, housing, social care and the third sector with a focus on securing and maintaining appropriate accommodation for vulnerable groups with mental health problems or a mental illness. The aims of the project were to:

- Gain a better understanding of good practice interventions that have positive impact and outcomes for both individuals and services;
- Identify key factors in housing support interventions which promote continued recovery and enable the individual to live successfully in the community;
- Promote and disseminate good practice and identify barriers to delivery.

1.11 The Welsh Government's Programme for Government provides the context for this work, emphasising the Welsh Government's aim to ensure high quality, integrated, sustainable, safe and effective people-centred services that build on people's strengths and promote their well-being. The Mental Health (Wales) Measure 2010 and 'Together for Mental Health' focus on how to improve the lives of people with mental health problems or mental illness including their families using a recovery and enablement approach. 'Homes for Wales: A White Paper for Better Lives and Communities' (Welsh Government, 2012 recognises the importance of meeting people's housing and other support needs through better integration of public services and better links between housing and health services.

"Integrated services are particularly important for disadvantaged individuals and groups, who suffer most when services are not joined up. It is for this reason that our approach to public service reform is centred around collaboration and designing services around people not organisations." (Homes for Wales, Welsh Government, 2012)

1.12 The Health and Homelessness Standards were re-launched in 2013 to reinforce collaborative arrangements. Local Authorities and their partners are also working more closely to commission Supporting People services, within which mental health and well-being feature prominently. The Housing (Wales) Act 2014 emphasises prevention of homelessness and improved services for those who do become homeless. The Act recognises the need for priority help for people

with disability or illness and has been strengthened further with specific reference to mental health in 'Standards for Improving the Health and Well-being of Homeless People and Specific Vulnerable Groups (Welsh Government, 2013).

1.13 The ESVG Board recognised that the experiences of practitioners in housing and mental health would be crucial in identifying good practice, what works, where the barriers exist, and how approaches could be further improved. A short survey questionnaire was developed and issued. The organisations contacted included: the eleven local authorities in Wales which retain a landlord function, thirty-seven developing housing associations, seven health boards, twenty-two local authority Supporting People programme commissioners, and a large number of Supporting People service providers. Key findings from the report include:

- For both health and housing, it is important to understand the holistic needs of each individual.
- Care plans may record accommodation needs as 'met' whereas the reality may be vulnerable people are being 'shoe-horned' into available provision due to a lack of effective forward planning for accommodation needs for people with mental health problems or a mental illness.
- Health workers feel housing providers are reluctant to house people with an identified mental illness.
- Housing workers feel their health colleagues withdraw after the housing allocation is agreed, leaving them with little or no support to help manage a situation that can result in rent arrears, anti-social behaviour, neighbour complaints and loss of tenure.
- A significant barrier to housing officers referring people to community mental health services was feeling 'out of the professional loop' with regard to referral for specialised health

support and/or primary health services, including accessing GP services.

- Accommodation is identified as a key area to support a person's recovery from mental illness. Care and treatment planning is a joint responsibility of Health Boards and Local Authorities to assess and meet the needs of people with serious mental illness. The current financial pressures experienced by both Authorities can result in a unilateral approach to the funding of Care and Treatment Plans. One example is the reduction of jointly commissioned care packages, inclusive of accommodation and support, which can be arranged between authorities to address the complex health and social needs of people with serious and enduring mental illness.
- Greater collaboration between the authorities is required to ensure that the level of need in each locality is appropriately captured and, with the right commitment of personnel and finances to create opportunities to develop services collaboratively across Health, Housing, and Social Care, to meet the complex Health and Social Care needs of people with Serious and Enduring Mental Illness.

1.14 In line with the available research evidence, the report concludes that integration and partnership working involving housing interventions can make a real difference to people's lives.

2. Methodology

2.1 It was determined form the outset, for various reasons, that an impact evaluation of the Scheme would not be viable. It was decided instead to adopt a more pragmatic evaluation design, examining the implementation of the scheme and relating this to its emerging outcomes.

2.2 The evaluation was theory-based and uses a logic model to describe a theory of change developed in conjunction with the Scheme's key stakeholders. A qualitative methodology was used to understand in detail the nuance of how the service works. Data was gathered through semi-structured interviews with practitioners and clients to describe the intervention and to assess short-term outcomes for the service and service users. Semi-structured interviews were chosen as the most appropriate methodology to gather rich data that explored the views, experiences, beliefs and motivations of individual participants. The semi-structured interviews consisted of key questions that allowed the interviewee to explore the areas defined in the logic model but also allowed for the discovery or elaboration of information that was important to participants but may not have previously been identified through the development of the logic model. Limited data was also collected from the mental health recovery STAR tool (see section 5) used by practitioners to plot the recovery journey and plan the support needs of individual clients. The evaluation was designed to:

- Examine the implementation of the scheme and to assess whether the project is operating as described by the logic model.
- Examine the extent to which the scheme contributes to the intended outcomes identified in the logic model.
- Draw lessons learnt for the scheme and implications for future sustainability and wider roll-out.

2.3 The evaluation approach was developed in conjunction with Cardiff and Vale Health Board. Face to face interviews were undertaken with eight out of nine NHS staff from the IRIS[2] team (one member of staff was not available during the fieldwork period), the three members of staff from Gofal[3] who support the Dispersed Housing Scheme, and four out of the six clients on the scheme (two declined to participate). Four key stakeholders from each of the partner organisations (Gofal, Vale of Glamorgan Local Authority, Newydd Housing Association and Cardiff and Vale Health Board) were interviewed by telephone. A focus group was convened to develop the logic model for the scheme; senior representatives from Vale of Glamorgan Local Authority, Newydd Housing Association, Gofal, IRIS, Cardiff and Vale Health Board and Welsh Government attended.

2.4 There are limitations to how far the effectiveness of the scheme can be understood at this point in time:

- The DHS is a pilot, its size is limited and currently has 6 clients; because of this, and the unique nature of individuals' mental health, it would be very difficult to generalise based on the initial findings.
- The DHS is in its formative stages and evolving. The research provides a case study of the intervention while it is in progress and the evaluation itself will help to refine the approach further.
- Due to resource and data constraints it was not viable to conduct an economic evaluation or cost-benefit analysis.
- Outcomes for individuals cannot be attributed to the intervention alone, due to the range and complexity of the factors affecting mental health. To overcome this would require a far more sophisticated and lengthy evaluation process.

[2]IRIS - Intensive Rehabilitation and Integration Service, Cardiff and Vale Health Board.
[3] Gofal Cymru: a leading Welsh mental health and well-being charity.

2.5 The evaluation of the DHS made use of the recently developed 'Integrated Care Evaluation Framework (ICE-F) (Carnes-Chichlowska *et al.*, 2015). The framework was developed to assist services providers in designing and undertaking evaluations of integrated services in order to assess their impact. This ICE-F was, commissioned by the ESVG Programme who intend for this framework to become widely adopted as means of robustly and consistently evaluating services, while accounting for local differences in approach, context and mechanisms. The framework acts as a guide to shape the approach and is not followed rigidly. Developing the evaluation of the DHS within such a framework provides a platform on which to build larger more rigorous evaluations of this and similar schemes in the future.

2.6 The foundation of the ICE-F is theory-based evaluation, where evidence about a service and its users is gathered to test a logical theory of how the service should work. The framework incorporates elements of Realistic Evaluation, the underlying premise being that social programmes/interventions are based on implicit and explicit assumptions about how programmes (service models) will work. Realistic approaches embrace the complexity of the real world and are designed to help answer 'what works, for whom, in what circumstances, in what respects and how'?

2.7 The conceptual building blocks of Realistic Evaluation are:

Figure 1. Context-Mechanisms-Outcomes configuration (adapted from Carnes-Chichlowska et al., 2015)

Context (C)	The features of the operating environment and conditions that are relevant to how successful those mechanisms are in meeting their intended purpose (negating or conducive).
Mechanisms (M)	The process or processes of how subjects/beneficiaries of a programme respond to the resources and opportunities provided by the programme.
Outcomes (O)	The intended and unintended consequences of implementing a programme, which can be mixed and multi-layered.

2.8 Context-Mechanisms-Outcomes (C-M-O) configurations are models showing how programmes are believed to produce their intended outcomes (Pawson & Tilley, 2011). The C-M-O configuration of the ICE-F is an appropriate fit for the DHS evaluation as:

- The context for the project is very important in driving outcomes for both individuals and the service itself and for understanding why some intended outcomes may not be achieved.
- The mechanisms of how the project works need to be properly understood if the scheme is to be expanded and replicated in other areas or settings.

2.9 In the context of the evaluation of housing support for people with mental health problems in the UK and wider EU the evidence base is quite weak (Pleace & Wallace, 2011). The DHS model is not underpinned by empirical theories of what works based on rigorous evaluation; it is founded on implicit assumptions on how the model of care should work and how it should improve on what existed before. Developing a logic model with key stakeholders was designed to explicitly articulate this.

The Dispersed Housing Scheme evaluation methodology within the ICE-F

2.10 The ICE-F has three stages, with a number of steps within each stage. This provides a useful structure for setting out the methodology of this evaluation.

Stage 1

2.11 The first stage is to outline clearly what the service has set out to achieve (its intended outcomes) in terms of the national policy context, local commitments to service provision and for service users themselves. The ICE-F describes a number of steps designed to visualise the service model and ensure there if consistent understanding of what it is, how it works and what it aims to achieve. In their report 'Demonstrating the Effectiveness of Housing Support Services for People with Mental Health Problems: A Review', Pleace

& Wallace (2011) repeatedly stress the importance of ensuring that the process and outcomes of service delivery are properly understood. If the process of service delivery:

- is not properly understood, it is not clear what services are doing to achieve positive outcomes or what they are failing to do if outcomes are negative.
- is not mapped with sufficient precision and detail, it is not clear exactly what services cost, which means cost effectiveness cannot be properly assessed.
- is not fully described and understood, then good practice in service delivery cannot be replicated properly elsewhere.

2.12 Prior to the commissioning of the DHS evaluation the Effective Services for Vulnerable Groups policy team within Welsh Government had begun to describe and visualise the DHS service model. During the development of the research specification a more detailed understanding of the service model emerged through discussions with key stakeholders. These meetings provided some of the national and local context (C), an outline of the service model (M) and some intended outcomes (O). These were incorporated into an evolving logic model.

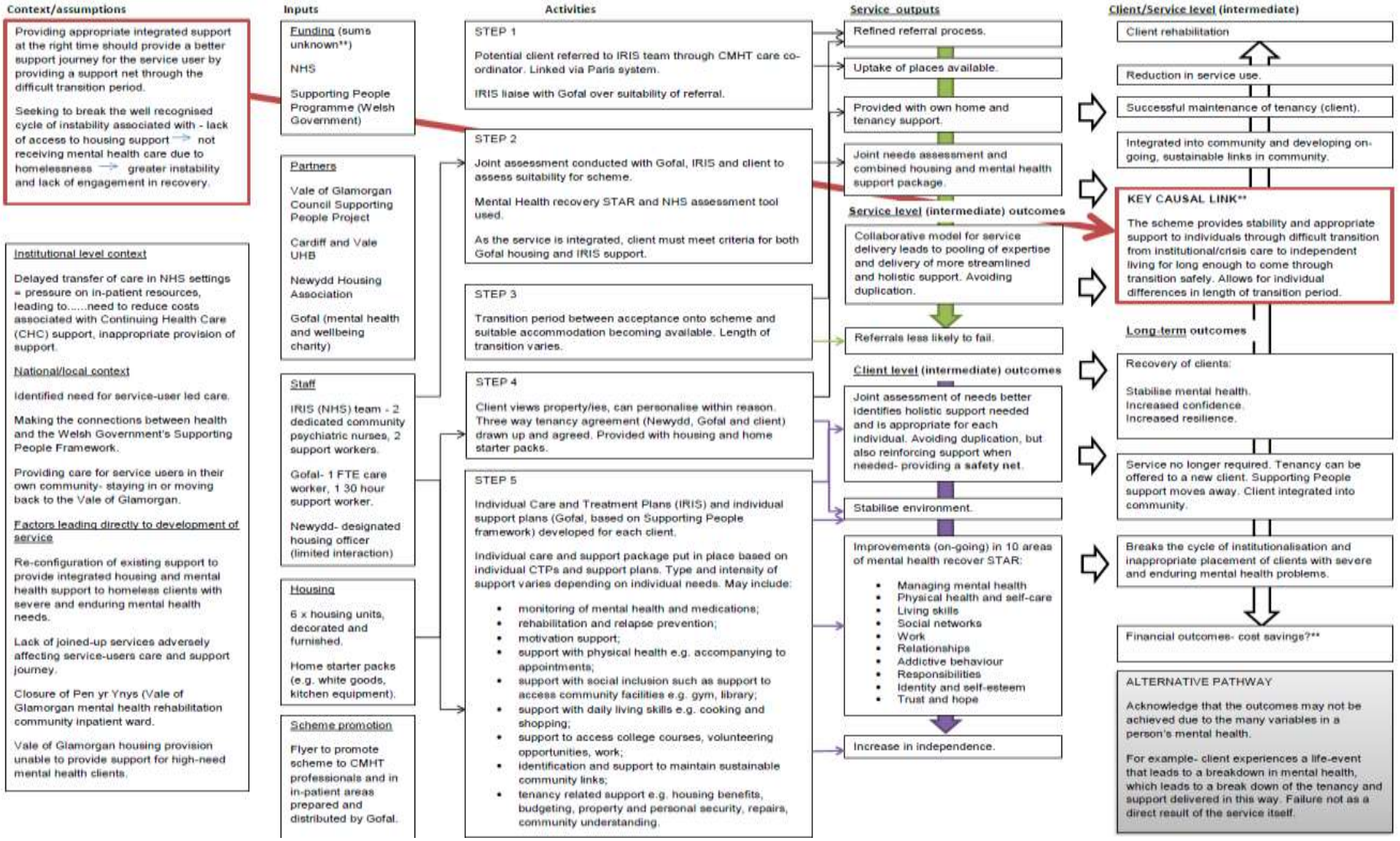
Stage 2

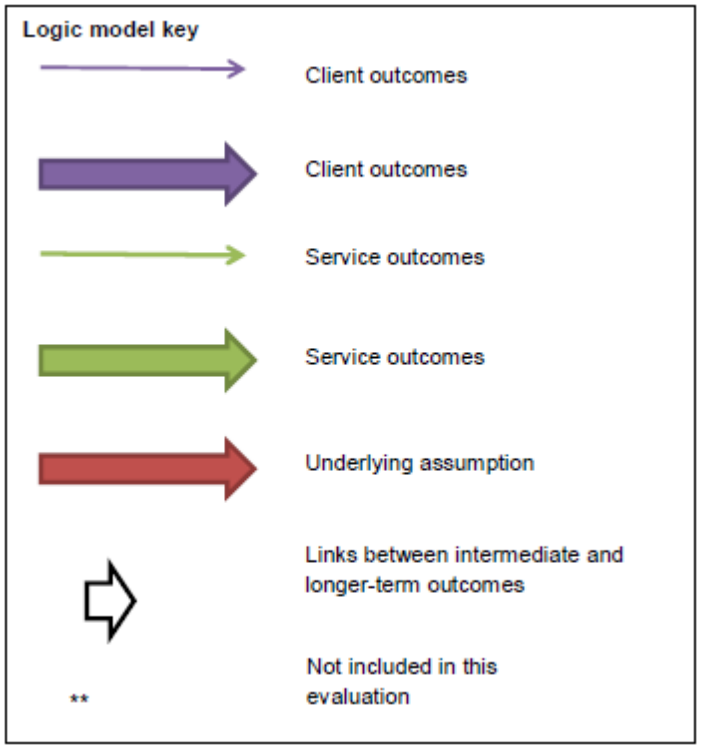
2.13 Stage 2 of the ICE-F aims to develop the logic model further by examining it against the C-M-O model. For the DHS evaluation key stakeholders and practitioners attended a focus group to help articulate the intervention logic, from which the logic model was then developed (see figure 2).

- The focus group resulted in a clearer articulation of the underlying context for the service model at an institutional, national/local and individual level (first column). Further contextual information was gathered through telephone interviews with key project stakeholders (see section 5).

- The logic model sets out intended outcomes for both the service i.e. the impacts of the collaborative, integrated approach to service delivery, and the service users.
- The logic model differentiates between intermediate outcomes (which where explored for the evaluation) and long-term outcomes (which were not a focus of the evaluation due to the need for longitudinal evidence that was beyond the scope of the research).
- The logic model also articulates the theory of change for the Scheme. The underlying assumption revealed is that **the DHS service model provides integrated support that will provide an improved support and recovery journey for the service user**.
- Through the inputs and activities described in columns 2 and 3 of the logic model the service provides the mechanisms to **deliver support in a collaborative way, which closes the gaps and provides a safety net during the difficult period of transition**.
- The logic model also suggests an alternative pathway, whereby the service may fail to achieve its intended outcomes due to the complex nature of mental health itself, rather than service failings.

Figure 2. A logic model for the Vale of Glamorgan Dispersed Housing Scheme




Logic model key
Client outcomes
Client outcomes
Service outcomes
Service outcomes
Underlying assumption
Links between intermediate and longer-term outcomes
Not included in this evaluation
**

2.15 The user-led nature of mental health and housing support, and the emphasis on personalisation of service is a key element of the DHS. It is therefore important that user perceptions of how well services work, and to what extent they feel they are being helped is integral to the evaluation design. While acknowledging the importance of including the service user voice, in practice this proved difficult. Incorporating the voice of the service user was not in itself difficult (interviews were conducted with four out of six clients); gaining usable data from this vulnerable group proved challenging. The data collected through clients offer some insight into outcomes for individuals, but their validity is limited by:

- the nature of clients' mental illnesses, which can, for example, influence the way questions are perceived;
- the fact that some clients also have learning difficulties, which caused problems with recollection, for example;
- clients' trepidation about being interviewed;
- time and resources - a more iterative approach is often necessary to gain clients' trust and reassurance, which makes for more productive interviews and more valid data.

2.16 Pleace & Wallace (2011) suggest the best way to collect service user data is through semi-structured face to face interviews. However, caution should be exercised in using data captured in this way due to the variable nature of mental illness. A more successful approach may have been to collect service user data through a series of short meetings designed to develop rapport and trust, rather than a 'one off' face to face interview. Interviews with practitioners revealed their perceptions of whether the service is working well and is achieving the outcomes identified in the logic model. The evaluation did not seek to measure progress against outcomes and no measureable indicators had been developed. Some outcomes data is collected and returned as part of the Supporting People data requirements, and over time may be used as one type of indicator of service effectiveness. These

data were not included in the evaluation due to resource constraints. Service user outcome data are collected through the Mental Health Recover STAR tool. The tool is for adults managing their mental health and recovering from mental illness. It is based on an outcomes model that allows people who are recovering from mental illness to think of their recovery as a journey (see section 5 for further detail). The STAR is repeated periodically and the available data were used in this evaluation to provide client's perceptions of their progress. Although the STAR data are subjective, they can add useful context to objectively measured outcomes.

Stage 3

2.17 Stage 3 of the ICE-F identifies the need to establish a counterfactual i.e. what would happen if the service wasn't delivered or was delivered in a different way. Providing a true counterfactual was beyond the scope of this evaluation, and would prove very difficult to achieve in any circumstances. This limits the degree of certainty with which outcomes can be attributed to the Scheme. Practitioners were asked to give their professional opinion on what may have happened had clients not been offered a place on the scheme to explore the potential impact of not providing this service and the likely journeys of service users without it. The practitioners interviewed were well placed to do so due to their level of experience, their prior knowledge of most of the clients and their experiences of delivering other models of support. Service users were also asked to reflect on their prior experiences and what may have been their journeys without the service; limited data were collected.

2.18 The ICE-F also suggests undertaking an evaluation of the cost effectiveness of a service. While a financial outcome - potential cost savings - was identified as an outcome in the logic model, financial implications were not within the scope of this evaluation due to resource constraints.

3. Origins of the Vale of Glamorgan Dispersed Housing Scheme

3.1 The Vale of Glamorgan Dispersed Housing Scheme consists of a multi-agency group who came together to focus on agreeing a service model appropriate to the needs of those with mental health problems in the Vale of Glamorgan. The Dispersed Housing Scheme partners are:

Gofal Cymru: a leading Welsh mental health and well-being charity. It provides a wide range of services to people with mental health problems, supporting their independence, recovery, health and well-being. Gofal also lobby to improve mental health policy, practice and legislation, as well as campaign to increase public understanding of mental health and well-being.

Cardiff and Vale Health Board: Cardiff and Vale University Health Board is one of the largest NHS organisations in Wales. It employs approximately 14,500 staff and provides health services to a population of around 472,400 people living in Cardiff and the Vale of Glamorgan. The IRIS (Intensive Rehabilitation and Integration Service) team provides intensive support in areas such as activities of daily living, relapse prevention and psycho-education to clients with the aim of integrating them into the community, accessing local facilities and resources and providing support to help them reach their full potential. The service is nurse-led and supported by multi-disciplinary community mental health teams. The team has strong partnerships with Housing Associations and third sector providers. Nursing support is available seven days a week.

Vale of Glamorgan Local Authority Supporting People team: In Wales the Supporting People programme is delivered by the Welsh Government and Local Authorities through a single revenue funding stream called the Supporting People Programme Grant. The aim of the Supporting People programme and therefore housing related support services is, through the provision of support, to:

- enable vulnerable people to increase or maintain their independence,
- prevent people from becoming homeless,
- meet the needs of people who have experienced homelessness,
- meet the needs of people who may be threatened with homelessness in the absence of housing-related support and to
- maintain individuals' tenancy and accommodation.

Newydd Housing Association: Newydd is a charitable housing association that offers nearly 3,000 affordable homes for rent and sale to people where need is at its greatest in Mid and South Wales. The Newydd vision is simply to provide affordable homes and sustainable communities with excellent services to tenants and customers.

3.2 One of the main driving factors behind the decision to develop the DHS was the closure of Pen yr Ynys in Barry. Pen yr Ynys was an NHS ten bed in-patient unit in Barry which provided care for people with high level mental health needs and also had a number of local authority beds used for respite care. Following an NHS census and a UK wide benchmarking exercise it was decided that there were too many in-patient rehab units, and as Pen yr Ynys was not felt to be used appropriately due to the number of local authority respite beds, it was closed in 2011. This then left a gap in the provision of mental health care in the Vale. Cardiff and Vale Health Board understood that they needed to expand their mental health supported housing team (IRIS) into the Vale to provide floating support.

"There was nothing prior to Pen yr Ynys, and there was nothing afterwards."

3.3 Gofal Cymru has nearly 15 years experience of working with people with mental health needs in the Vale. Their experiences and observations, alongside data collected through their involvement in

the Supporting People planning process, combined with the closure of Pen yr Ynys, led to the conclusion that there was an under provision of housing and support for people with mental health needs in the Vale.

"It was clear that there was need for further supported housing, perhaps alternative models of supported housing. We were experiencing difficulty in accessing those services for our beneficiaries, so very often we'd be looking to make referrals to projects in Cardiff or elsewhere simply because there wasn't the availability in the Vale."

The Vale of Glamorgan's Supporting People teams' annual planning process showed that:

"…mental health came up as a huge unmet need in the Vale…"

3.4 While low level mental health needs were being met to a certain extent by floating support services funded by Supporting People, high level needs were not being supported and support workers found it difficult to get directly into the health services needed to stop people from reaching crisis points and needing to be admitted to hospital. Crucially, it was recognised that housing support for people with high level mental health needs also needed to link into healthcare.

"So we needed to change what we had to have that link into health as well."

3.5 Successful dialogue and collaboration between the key project partners allowed a new service to be reconfigured from the floating support service commissioned in the Vale of Glamorgan, funded by Supporting People and delivered by Gofal Cymru. It provided between four and five hours of housing-related support each week to eight people within their own homes. Prior to reconfiguration into the dispersed housing model the service was unsuitable for service users

with much higher needs and who required accommodation and continued support from Health on their release from hospital or institutionalised care. The expansion of the IRIS team into the Vale allowed the Health aspect of their care to be fully supported alongside their housing and other support needs. The need to make the connections between health and housing was a key aspect of the collaborative approach taken to service design.

3.6 The dispersed housing model offers clients their own tenancy in a one bedroom flat in their home community. The scheme currently has six clients, five in flats, and one awaiting a place (at the time of writing this report). The Vale of Glamorgan team had observed that often the properties provided weren't necessarily appropriate accommodation in the appropriate place that could support people's recovery.

"…a lot of the time, the properties that people were living in weren't really in very good areas, they were just what were available at the time and people were having to take those properties without any account of being taken that probably the surrounding areas where these properties were wasn't very conducive for their recovery."

3.7 The observations of two of the clients illustrate this point. One client had previously been in private rented accommodation, they received limited support and the tenancy broke down quickly. They were unable to manage their illness or tenancy. Another client was concerned that without a place on the scheme they would be put in yet another hostel in an environment that wasn't good for them (the influence of alcohol and drugs) and without any real privacy.

"I'd have to go to Marland House in Cardiff or maybe Barry, well I don't know…and they'd probably put me in a hostel, which I don't want to go back to…because there's drugs and drink and I want my own place, not just a room, privacy."

3.8 Newydd Housing Association, working alongside Gofal is responsible for sourcing the appropriate accommodation, ensuring that suitable tenancy agreements are established and that everything is in place to

support the sustainability of those tenancies both for the individual and the surrounding community as well.

"…the fact that the dispersed model offered something different, shared supported living isn't necessarily appropriate for everybody, so enhanced the mental health offer."

3.9 Agreement was reached in August 2013 and the existing scheme was remodelled to introduce an integrated dispersed supported housing scheme, comprising Housing Related Support from Gofal Cymru support workers and Specialist Rehabilitation provided by Qualified Nursing Staff and support workers from the IRIS team at Cardiff and Vale University Health Board. This hybrid model of support enables service users with mental health problems to take up their first tenancy with a fully integrated Care and Treatment Plan. The dispersed accommodation model is intended to be:

- Person centred.
- Self-contained accommodation.
- Designed to deliver support based on individual need.
- An integrated model of housing and clinical support…
- …delivered through collaborative agreements.

3.10 Initially, it took some time to come to agreement about the type of property that would be used to house clients on the scheme and there was some frustration on the part of clients and practitioners over the length of time it took to find suitable accommodation. Strong dialogue and a commitment to a shared vision that evolved through collaboration enabled these challenges to be overcome.

3.11 Prospective clients are jointly assessed by Gofal and IRIS prior to taking up their tenancy and a care and support plan is agreed. Gofal Cymru support workers provide housing related support as well as support with finances, daily living skills, socialisation and work. The IRIS team support the clinical mental health needs of clients as well as offering specialist rehabilitation through therapeutic techniques and

support with daily living skills (see section 3.2 for more detail on the exact role of each organisation).

3.12 The key project stakeholders feel that the DHS provides integrated care in an appropriate setting in a way that is right for each individual where risks are managed so that they can be given the opportunity to progress in their journey towards better mental health and being part of their community. The scheme is intended to be part of a progression not an end point in itself.

"The approach we've taken as well in entering into the collaborative arrangement with IRIS meant there was an integrated service. Very often housing and health operate differently, separately, don't have shared protocols. This way we had the opportunity of integrating the service and providing a hybrid model of support that I felt and everybody felt was unique."

"We have to think of people in a more holistic way, we can't just be thinking of a symptom or an illness, for people to be truly integrated in their society they have to be able to live and do those basic activities of daily living, but also aspire to those other things as well such as being more productive, getting into education, working, being part of the community in a productive way and feeling that benefit to society as a whole. And I think the DHS definitely puts the service user on the right steps towards achieving that. It's not just the IRIS team doing that, the Gofal team are doing that, there are other agencies we can bring in to support that person, and transfer onto another service who can help the client on that journey."

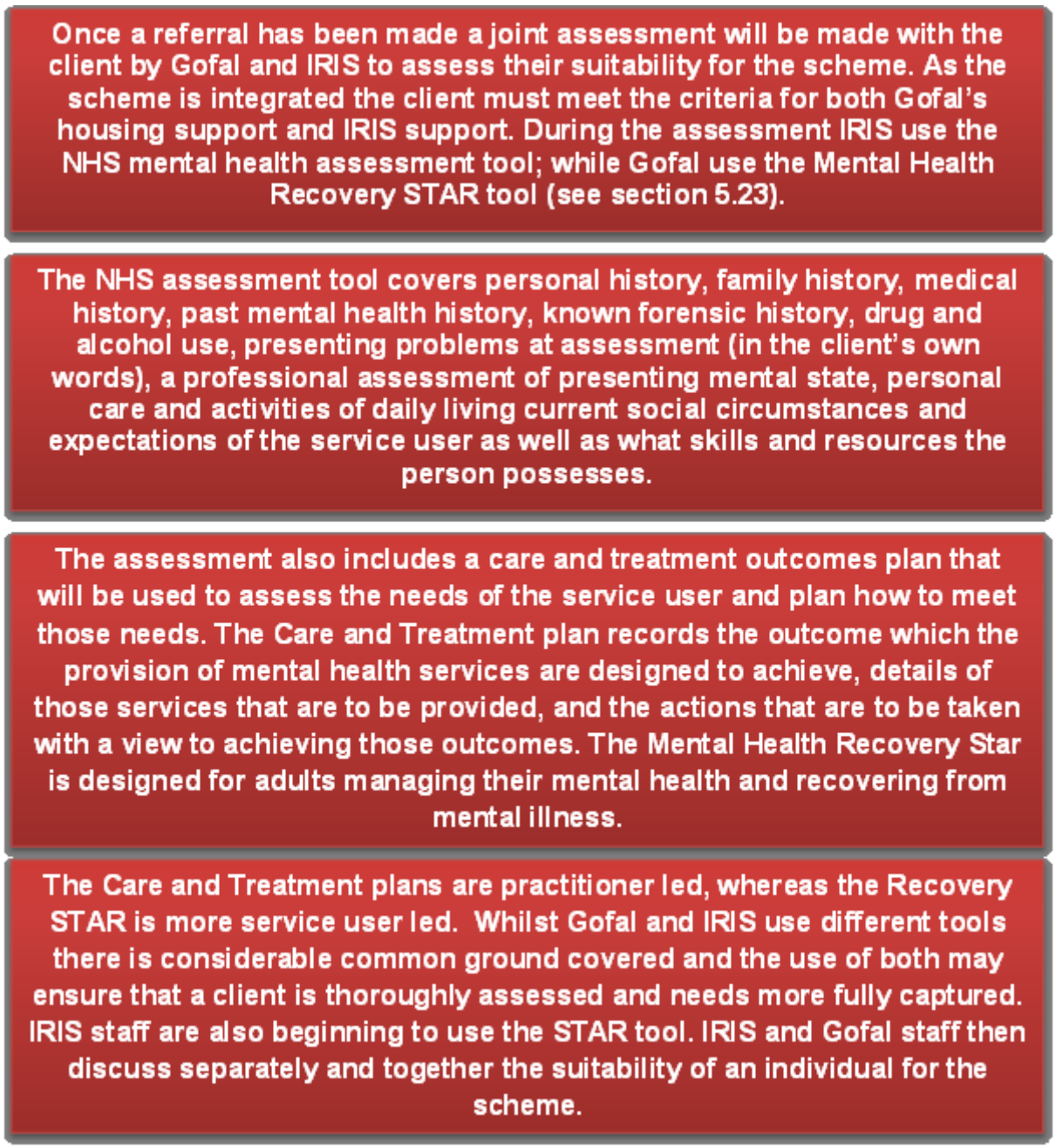
4. How does the Dispersed Housing Scheme work?

Referral and assessment

4.1 Potential clients are referred to the service through a number of routes. Some clients have been known to the IRIS team for some time from their shared supported accommodation service. If a client within the IRIS shared supported housing service should express the desire for greater independence and the team feel that they could be suitable then they may be referred to the dispersed housing scheme. Gofal have a presence on some Cardiff psychiatric wards and may come across referrals this way. Other referrals may come through Community Mental Health Team care co-ordinators (who are linked to the IRIS team through the Paris system) and Clinical Psychiatric Nurses.

4.2 As the dispersed housing scheme is currently a pilot and the amount of suitable accommodation is limited both Gofal and IRIS have been careful about raising its profile so as not to exceed supply. Both Gofal and IRIS noted that assessing the level of need for the service was difficult, especially whilst the service maintains a low profile. The following process for referral and assessment is undertaken:

Figure 3: The DHS process for referral and assessment



"…when we do our initial assessment our paperwork is quite different ……some things cross over and some of the questions could be used to answer some of the things that they're looking at on the recovery STAR, we incorporate that as well in our assessment. The other day… and I did an assessment, and we were interlinking the questions…might ask something relevant to the recovery STAR that's relevant to my assessment as well and vice versa."

4.3 Six clients have been provided with places on the scheme, although one is awaiting tenancy at the time of writing. The clients are in their twenties and early thirties, five are male, one is female.

Staffing

4.4 The initial assessment is undertaken by Gofal and IRIS staff who then provide clients with support. Gofal currently have three members of staff committed to the project- the project manager, one case worker and one support worker. The IRIS team has members of staff who support both Cardiff shared supported housing and the dispersed housing scheme in the Vale. The IRIS team is made up of the IRIS team manager (Clinical Psychiatric Nurse, CPN), deputy manager (CPN), three CPN's and three support workers. Initially the IRIS team was split between staff supporting clients in the Vale and those supporting the shared accommodation in Cardiff. However, in order to provide greater coverage and flexibility (for example in the event of staff illness) all the IRIS team now cover Cardiff and Vale. This also means that the clients on the dispersed housing scheme get to know all the IRIS staff.

"…but I didn't want it to be two teams in one, I wanted it to be one team and have flexibility across the team that enabled everybody……to know everybody, so that gave me greater flexibility…"

4.5 The project is monitored by a steering group made up of staff from Gofal, the IRIS team, Newydd Housing Association, the NHS and the Vale of Glamorgan Supporting People team.

Transition

4.6 When a person is assessed as suitable for the dispersed housing scheme suitable accommodation will then be sought. As there have been instances of delays in sourcing suitable accommodation, a number of clients have waited some time in their present accommodation before moving into their flat. However, as soon as they are part of the scheme Gofal and IRIS begin working with them and providing support. This allows a period of transition where the scheme staff can get to know service users, develop rapport and trust and start to work with them on areas identified through the initial assessment. They are also encouraged to join in with group activities delivered by IRIS and Gofal. The length of this transition period varies and clients may become frustrated during this time.

"It didn't come around quick enough. I had to wait for a year before it started…"

"Sometimes I get a bit fed up, I just want my own place now."

4.7 During this time IRIS will develop a Care and Treatment Plan for each client that will take into account their support needs and individual goals. At the same time Gofal will discuss needs and goals with clients based on the Recovery STAR model. IRIS also develop an intervention care plan for each client that covers areas such as physical health care, therapeutic needs and crisis interventions.

Accommodation

4.8 Each service user is provided with a two year tenancy in a one bedroom flat in the Barry area. The housing is sourced and let by Newydd Housing Association and a three way tenancy agreement between Newydd, Gofal and the client is drawn up and agreed. The flats are all either in or close to Barry town centre. Clients have the opportunity to view potential accommodation before deciding to take the tenancy. Newydd seek to ensure that the tenancies are sustainable both for the individual and the surrounding communities. Gofal are responsible for decorating and furnishing the

accommodation through PS Facilities Management, their associated social enterprise, and providing a home starter kit containing items such as white goods and soft furnishing.

Support services

4.9 Each client on the scheme has individual, ongoing needs and these are recognised during the initial assessment, the transition period and subsequent Recovery STAR conversations. Gofal provide support during the day, while IRIS also provide an evening and weekend service, although the support is not 24 hour. The level of support provided varies depending on client need. Staff will visit clients at their own home and either work with them there or go out in the local area. There is some overlap between the support provided by Gofal and IRIS staff particularly with support in areas such as personal care, harm minimisation, daily living skills (e.g. shopping, meal planning and cooking), support to access college courses, volunteering opportunities and work, social inclusion, and relapse prevention.

4.10 Tenancy related support e.g. housing benefits, budgeting, property and personal security, repairs and community understanding is provided by Gofal staff. At the beginning of the tenancy Gofal's involvement will be quite intensive as they support the client in setting up their own home- ensuring that they are comfortable and secure, getting benefits in place, ensuring paperwork is completed, ensuring that they understand things such as how the recycling works or who to call in an emergency. As the client becomes more independent and confident, Gofal's support in this area may decrease to around one or two visits a week.

4.11 IRIS staff support the monitoring of mental health and medications, support rehabilitation and provide relapse prevention, particularly through therapeutic interventions such as Cognitive Behavioural Therapy, Dialectic Behavioural Therapy and Motivational Interviewing. IRIS staff also support clients with their physical health by for example accompanying them to appointments.

4.12 Both Gofal and IRIS provide additional support through group activities. IRIS run a breakfast club for all its service users, which the Vale clients are welcome to attend. They run pool and football groups for clients in the Vale, and also take service users on holiday. Gofal run a service user participation group in the Vale once a month for current and past Gofal service users; all the Dispersed Housing Scheme clients are encouraged to attend.

5. Findings (analysis of interview data)

Client outcomes

5.1 The logic model (figure 2) outlines the intended intermediate and long-term client outcomes of the project. The intermediate outcomes identified were:

- Identification of holistic support.
- Provision of a safety net of support.
- Stabilise environment.
- Increased independence.
- Improvements in the ten areas of the mental health recovery STAR (see section….).
- Client rehabilitation.
- Reduction in service use.
- Successful maintenance of tenancy.
- Integrated into community and developing on-going, sustainable links in the community.

5.2 The long-term outcomes identified were:

- Mental health stabilised.
- Increased confidence.
- Increased resilience.

5.3 During the research the client outcomes were investigated through questions to service practitioners, client interviews and (limited through time pressure) access to the STAR data of five out of six clients. The majority of the observations on client outcomes come from service practitioners and relate to their observations on what the scheme can provide and changes and improvements in clients. A number of the service practitioners have worked with the clients for many years prior to their entry on to the scheme and are therefore well placed to comment on changes in mental health, behaviour and lifestyle. While long-term outcomes cannot be identified as part of this evaluation due to the approach taken (see section 2) some observations on longer-term outcomes are provided by the evidence.

The data collected from client interviews is of limited use and validity (see section 2) but does in some cases provide useful insight.

Intermediate client outcomes

- Identification of holistic support.
- Provision of a safety net of support.

5.4 While the joint assessment and development of an integrated care and support plan provides for the identification of a wide range of support needs for each individual client, it is the time and space that practitioners have to build relationships with clients that allow the development of more person centred care. Mental health support packages can often be 'chaotic', making it difficult to identify and find the right support individual needs. The development of a structured individual plan and the time and autonomy to work with each client allows gaps in needs to be both identified and filled, and at times for more subtle needs to be picked up. The scheme also allows people to receive this support in their own home environment.

"It's a luxury to be able to work with people and to give them that time to progress without too much pressure, and to recognise their own pace, and to be a part of that is something new to me because it's just much more structured…"

"… you get more autonomy and more freedom to work with the clients and… more engaging, because you're not just stuck in a house or an office just doing your one to one, you're actually getting out there and showing the guys that there is a world as well to work on their motivation levels. Even if you get a twinkle of something you can work on that, and help grow it, and help support and assist them……For them you're not just structured in a way that you would be in hospital or in an office, you get to do stuff with them that helps them, but it's in their environment, that's where they want to do it. I think it helps."

5.5 A number of the practitioners described the support package offered by the Dispersed Housing Scheme as a 'safety net'. It provides the clients with the opportunity to have and develop their independence, but with the safety of the support provided by Gofal, IRIS and other agencies around them. It allows them to take risks, but in a sensible and managed way (see section 5.57 on risk management).

Stabilise environment.

5.6 Practitioners were asked to reflect on and were able to draw on the past experiences of the clients on the scheme to provide a picture of the change in environment for the clients since entering the scheme. They painted a picture of previously chaotic lives, characterised by numerous episodes of crisis resulting in hospital admissions and stays in institutionalised care. Periods of living at home were often characterised by difficulties in familial relationships which had a detrimental effect on mental health. Some clients had been living in shared supported accommodation or private rentals, which again had detrimental effects on their mental health or did not contribute to positive recovery. The long-term effects on the stability of the environment for clients, both in terms of health and recovery and their tenancy cannot be revealed by this evaluation nor can a causal link be proven between the scheme and the outcomes due to the lack of a counterfactual. However, two key facts that speak for the present success of the scheme are:

- There has been no re-admission to hospital due to a relapse in mental health since the scheme started.
- There has been no breakdown in tenancy.

"I think the fact, again some of the people we've worked with have had, even though they're quite young, long periods of mental health problems already and a number of admissions, some under detention, sectioning under the mental health act, the fact that people haven't required to go back into hospital even though they're living independently."

5.7 For example, one client has been stuck in a cycle of poor living environment at home to institutionalised care and back again for a very long time. Their combination of mental health problems and learning difficulties mean they will likely always need a high level of support. However they now have the opportunity to be independent and have their own space and a sense of control for the first time in their life. They have not required hospital readmission despite a long history of non-compliance with medication. Another client, who has shown a great deal of improvement, has gone from fluctuating from one difficult home living arrangement to another in between numerous hospital admissions to successfully maintaining their tenancy with limited support, developing good social networks and a strong goal of getting back into work. This client also has a history of non-compliance with medication but is now able to maintain their medication and have insight into why it is so important.

"...more responsibility now and also I'm in my own place so I have to make sure I'm taking it regularly and properly..... when I took it, I actually gave it a chance, because before I didn't want to take it at all, so when I decided to make sure I keep taking it I saw a difference in my mental health and everything else felt easier and better. I felt better in myself.....if I wasn't taking my medication I probably wouldn't have been offered this place, so that's part and parcel, make sure I take my medication and keep this place."

Integrated into community and developing on-going, sustainable links in the community

5.8 The end goal of the scheme is for clients to require less support over time until they no longer need the support of the Gofal and IRIS teams. A critical aspect of this is the development of on-going, sustainable links in the community. Both Gofal and IRIS run group activities for tenants such as breakfast clubs, pool group, football group and client group. This provides clients with the opportunity to get out of their flat, meet the other clients on the scheme and

socialise. Attendance at these groups varies and the lack of a constant meeting place in the Vale limits the opportunity to provide a drop-in 'hub' for staff and clients. The evidence that clients are developing links in the community above and beyond the friend and family networks they already possess is limited. Gofal and IRIS provide clients with information about volunteering opportunities, interest groups and learning opportunities but there isn't much evidence of progress being made in this area. Two clients have recently expressed interest in volunteering. One acknowledged that getting into volunteering would support him in getting back into paid work and would help him feel more part of the community.

Likely tenant journeys

5.9 The lack of a counterfactual means that it is not possible to investigate what may happen to an individual with high mental health needs who does not have a place on such a scheme. To provide some insight into this practitioners, who both have knowledge of the sector and long-term knowledge of individual clients, were asked to reflect on what might have been the likely journey of clients had they not been offered a place on the scheme. A number of common themes emerged all relating to breakdown in mental health and instability:

- Homelessness.

  "…. offers of accommodation would probably have varied drastically because they would probably have had to go through homelessness…."

- Being placed in unsuitable, inappropriate accommodation.

  "…a lot of the temporary accommodation in Barry includes shared houses, which quite often is where prison leavers are housed when they're homeless and other homeless cases. Those environments are quite chaotic……and there isn't staff on site….. People can be in temporary accommodation awaiting allocation of permanent accommodation for up to two years sometimes."

- Breakdown in living arrangements.

  "…quite often those placements break down because people have those negative influences around them. There tends to be quite a lot of drug use, people tend to be quite chaotic and there isn't the support structure in place for people to be able to manage that accommodation, they quite often break down and can be a bit of a revolving door."

- Living at home with familial issues that cause great strain on mental health, including domestic abuse.

  "…where they were living before as I say there were compounding issues, for most of the clients, and that consumed them, and that affected their mental health so it kept them in a very small cycle."

- Being stuck in a cycle where breakdown leads to a crisis, the individual is placed in institutional care and then inappropriate care on release, which may lead to further breakdown.

  "People are homeless, placed in temporary accommodation and then are not able to manage, if they've had a history of negative social influences, negative coping mechanisms; they haven't been able to manage their mental health appropriately...if you've got somebody across the hallway from you who is using substances has got people coming to the house, the temptations are there and people will fall into what they're use to do, so it's very difficult to break those cycles and to encourage people to form positive social networks and good coping strategies because they're surrounded lots of negative influences."

- Self-harm.

  "…another route could've been they could've hurt themselves where something irreversible could've happened, or they could've been sectioned into hospital…"

- Substance abuse.

  "I think if they didn't come into this environment I'm sure they would still be in Whitchurch if not worse, because they were taking a lot of drugs, they were drinking, their lifestyle was atrocious. They either would be a long-term patient in Whitchurch or Llandough soon to be, or maybe they wouldn't be here now, or on the streets."

- Lost to the system.

  "There's a possibility they might have fallen through the net and they would've been lost…"

Break in crisis situations

5.10 A key theme that emerged during practitioner interviews, which is related to the stabilising of environment, was that the DHS is able to create a break for issues that can escalate into crisis. The detailed, joint initial assessment of clients allows triggers for crises to be identified and relapse plans to be developed. Crucially, visits from both IRIS and Gofal allow issues that may cause stress e.g. problems with finances, and could lead to break down to be picked up early and dealt with more effectively to stop them from escalating. In other housing situations it is more difficult to do this. The intervention from health professionals allows issues of medicine non-compliance to be picked up and dealt with quickly, before they become problematic.

"It means you can deliver more appropriate interventions in a more timely fashion without some of the clunkiness of referrals, operating in isolation. I think relationships are stronger, and understanding of each element of the service is stronger as a result of the collaborative approach we've adopted."

"…because we work in a very tight multi-agency and we're quite good on communicating with each other both teams, and our clients are

very open and honest with us a lot of the time and they trust us, that gives grounding to deliver a different type of service…"

"…somebody may have a bereavement, things happen. We can manage that, as long as we're aware of it and we pull together and work together, we're confident that we can manage those things with people and help reduce the anxiety and stress that may come with that, which should keep things ticking along."

5.11 Situations have occurred during the course of the evaluation which have demonstrated the growing independence and resilience of clients and reduced likelihood of crisis (e.g. a situation involving the availability of medication while a client was away from the area was resolved with positive action from the client and limited intervention from services provided by the DHS.

5.12 The service practitioners identified a number of positive benefits that clients had experienced since entering the scheme. These are in line with the intermediate outcomes identified in the logic model.

Increased independence

5.13 The scheme provides clients with the opportunity to have a level of independence that they have never experienced before. Most have never lived alone in their own home. It provides clients with the opportunity to rebuild and move on with their lives. Practitioners recognised that the level of care provided in shared supported accommodation can create dependency. The dispersed model is designed to gently break that cycle of dependency by gradually building the independence of clients until they are able to cope with limited or no intervention. While it is likely that some clients will never achieve full independence, clients have shown signs of decreased dependence and greater ability to cope on their own. It is important that the clients have the goal of wanting to be independent. Examples include:

- Clients who have never worked or haven't worked for some time seeking volunteering opportunities.

- One client taking the train on his own for the first time ever to visit a friend some considerable distance away.
- One client taking up a new hobby and turning this into a training opportunity.

5.14 Greater independence is linked to growing confidence. The scheme allows clients to develop their independence and confidence in a **safe** environment. The greater independence opens up opportunities for clients to develop their confidence and their abilities to take on greater responsibilities for themselves in terms of their own self-care and in a wider way to engage more with life.

"It's giving that opportunity to start learning the ways of life…"

"They can get up and go out, come and go as they please, independence really, and it affects their well-being, makes them a happier person…"

"So to have as much independence as they're able to at the moment, and to have that successfully enables them to look at their long-term goals and their whole approach completely different……Whereas previously they may not have had any sense of what their aspirations were, or any sense of hope. Quite often people are very in the present and they're just dealing with their current situation and not able to see past that. So I think it's about giving people a sense of hope really that they can live independently…"

"I think there are advantages for being on their own for a client who wishes to be on their own, and strives to be on their own and don't like shared living whatsoever, I think then they're easier to work with, that they have that goal of staying independent, providing they have that goal."

5.15 Two clients are reaching a point where they are ready to start stepping down the amount of support they receive. One client is intending to maintain their tenancy in the flat on their own in around six months, with the continued input on medication monitoring.

Another client is looking likely for discharge from the service if they continue to show steady progress. A number of clients have shown greater confidence in taking responsibility for aspects of their own lives such as self-care, shopping and cooking and looking for volunteering opportunities.

"Thinking of one client in particular they have just changed so much, they are so relaxed, so confident, just their independence levels…"

Improvements in the ten areas of the mental health recovery STAR (see section 5.27)

5.16 The mental health recovery STAR identifies ten key areas[4] of improvement as part of the journey of recovery. Both practitioners and evidence gathered from client individual STARs show some improvement in most of these areas.

5.17 The key area of improvement identified by practitioners was to client's mental health. Improvements to mental health stem from:

- Stabilising the environment.

"I think it's really important that they feel that's their own home, they don't have to move on, especially those that have been in and out of hospital for years, they feel maybe grounded somewhere and they can build up their life really, and get their life back to as normal as they possibly can, back into society."

- Clinical intervention to ensure compliance with medication.
- The ability of staff to pick up on and support clients in areas of their lives creating stress and anxiety.
- The privacy and own space that comes with having their own home contributing to a sense of identity and improved happiness and well-being.
- A sense of self.
- Being in their own home environment with supportive family and friend networks around them.

[4] Managing mental health, Physical health and self-care, Living skills, Social networks, Work, Relationships, Addictive behaviour, Responsibilities, Identity and self-esteem, Trust and hope.

“It's a solid foundation then for them to develop their resilience and their ability to manage their mental health because the accommodation needs are taken care for almost so that's kind of in hand, so you've got the opportunity then to do the really important recovery work and developing that person's skills.”

“Definitely, the positive element is quite clear in how they function, living with a mental health problem. You can see it, relapse is less, it's...I haven't had a remission yet, touch wood, since we've started so that must speak for itself…”

“…one person in particular has been very unwell and they’ve just gone around in a small circle for a very long time because they were living at home with the domestic abuse and it was hard for them to make any progress, but since they’ve moved to the flat, ok it's not fast progress, they have learning difficulties and they will always have issues, they’re never going to be 100% independent as we know it. But for them, they’re loving life, they’re like "yes, I can watch whatever videos I want to watch, I can play what music I like, this is my home", even just that in itself it's a sense of pride a sense of self, that's crucial to becoming well and to have well-being.”

“... it could help with the way they feel in managing their mental health, by being independent, having their own place, they've got their own space, they can do what they want.”

“…happier, more stable in their mood, behaviour and mental state…”

5.18 The importance of developing a sense of self through the opportunity to have their own home, their own space and privacy was frequently cited as a benefit of the scheme.

“From that you see people's characters really coming into this flowering, once you've relaxed a bit and you have your own space, your creativity, your interests, people then start to develop because the environment that you may have been in before you just weren't able to do that, it hindered all those areas.”

“It's made them feel valuable I think. It's made them feel that they are finally a person, they're able to live like the rest of society, they're not in a house where they have to adhere to the rules of another tenancy agreement because they have to respect where they're living etc. They're at their own front door, they're in control, and with a little bit of support to help them have that control it makes them feel more valid, as the rest of society.”

5.19 The self-reported mental health recovery STAR data shows that clients have seen progress in several areas of their recovery journey. The largest improvements reported were in living skills, physical health and self-care and responsibilities. Practitioners also noted instances where clients were starting to take greater responsibility for daily living skills such as shopping and cooking and taking charge of their own environment as confidence grows.

“A lot of the time initially they don't want to make their own phone calls to report repairs, but we're seeing after about a year, thinking of a couple of the males on the scheme, they then ring me and say "oh I've rung Newydd for repairs now", so that's great to see that I can back off a little bit and start to watch their independence development, their confidence, they're ringing me and telling me that they've done those things then, whereas initially that's my role.”

5.20 The long-term outcomes identified in the logic model were:

- Mental health stabilised.
- Increased confidence.
- Increased resilience.

5.21 Although the evaluation cannot show what the long-term benefits of the scheme will be for clients the evidence outlined above on short-term and intermediate client outcomes demonstrates that the clients are on a positive journey towards those outcomes.

The relative youth of tenants

5.22 While the scheme does not have an age criteria, an emergent theme in the practitioner interviews was the relative youth of the clients on the dispersed housing scheme. Some are in their early twenties, others early thirties. While exploring the theme the following points emerged:

- The scheme can potentially pick up people at an earlier point in their journey and break the cycle of mental health relapse, tenancy breakdown, back into institutional care.
- It is possible that younger people are more willing to engage in their recovery and seek independence as a life goal.
- The scheme could teach clients essential life skills before their lack of independence becomes ingrained.
- Younger people who are supported well by family members may not have the opportunity to learn essential living skills and therefore lack the ability to live independently when family care can no longer be given (due to illness or death).

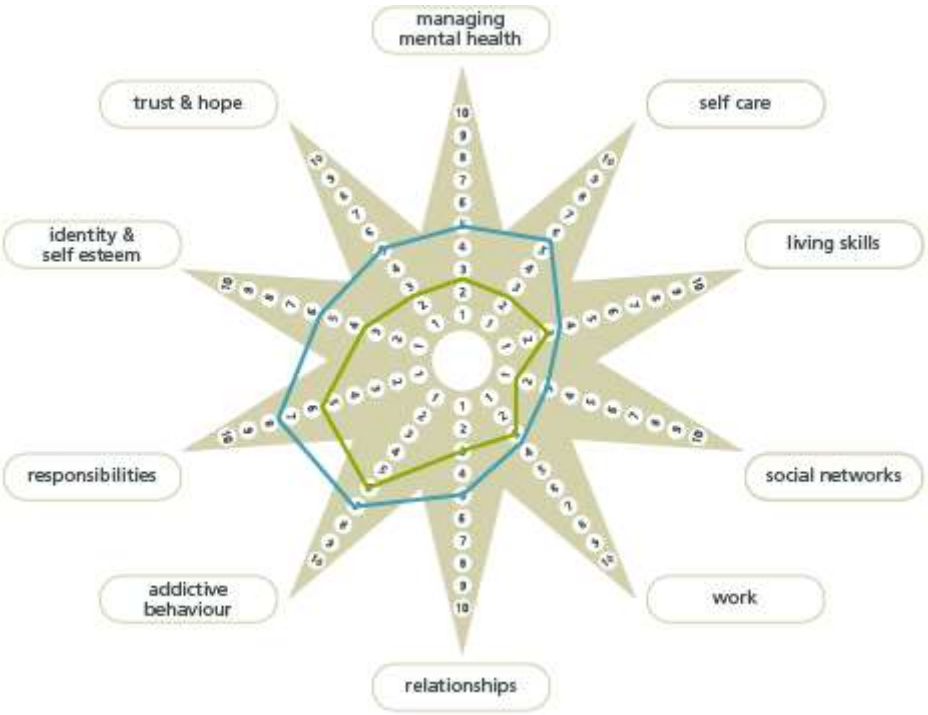
"...some of the people on this project are very young, some are in their twenties. Some have only every lived with their family and without this project they may have had to be supported by their family and then that becomes that much more traumatic when those family members are no longer here because that person then hasn't had the opportunity to develop their independent living skills."

"I feel that in light of the clients we have now, having been in the rehab service for a long period, if they had been identified when they were younger, if there'd been a scheme like this then there's a possibility it would've helped them…"

Use of the Mental Health Recovery STAR™ tool

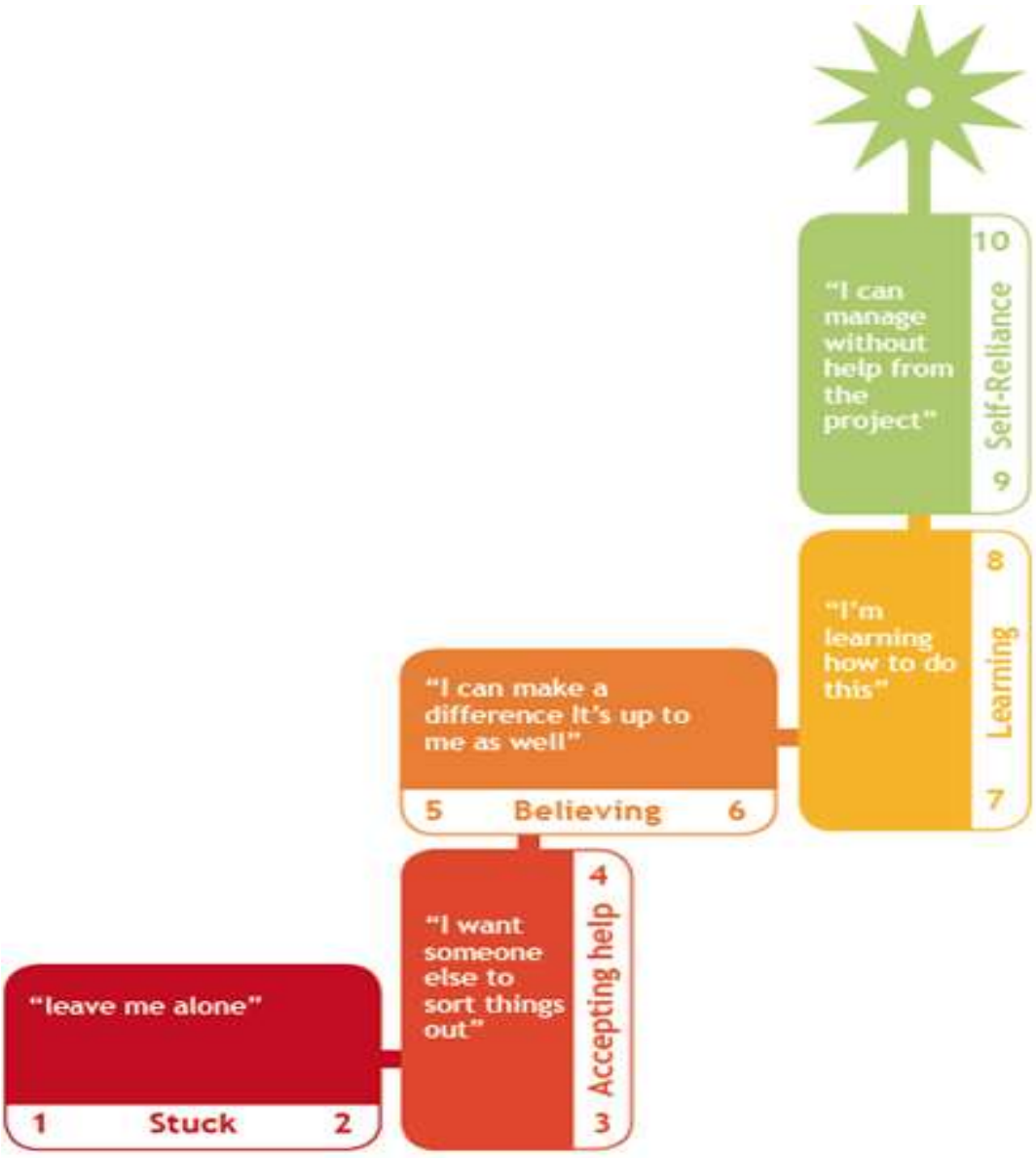
5.23 The Mental Health Recovery Star is designed for adults managing their mental health and recovering from mental illness. It is based on an outcomes model that allows people who are recovering from mental illness to think of their recovery as a journey. The Mental Health Recovery Star covers ten key areas managing mental health, physical health and self care, living skills, social networks, work, relationships, addictive behaviour, responsibilities, identity & self-esteem and trust and hope. The STAR is based on a ten point 'ladder of change' that covers five stages - stuck (not feeling able to face the problem or accept help), believing (can make a difference ourselves in our life. Start to do things ourselves to achieve our goal as well as accepting help from others), learning (how to make our recovery a reality), self-reliant. Figures 3 and 4 show elements of the STAR tool.

Figure 4. The Mental Health Recovery STAR showing how the journey is plotted on the STAR[5]



5 http://www.imaginementalhealth.org.uk/_uploads/Recovery%20STAR%20User%20Guide.pdf (accessed 24/09/2015)

Figure 5. The five areas of the 'ladder of change'[6]



5.24 The tool has been used widely by Gofal for some time on a variety of projects. Gofal use the tool as a way to assess client suitability and assess their needs for the dispersed housing scheme. The assessment is repeated at regular intervals to track the journey of clients. The tool is service user led, while some clients choose to use the scoring system alone, others like to write more detail against each area of the STAR. IRIS use a practitioner led system to assess client

6 http://www.imaginementalhealth.org.uk/_uploads/Recovery%20STAR%20User%20Guide.pdf (accessed 24/09/2015)

history and needs. While the paperwork looks quite different, there is synergy between the two and Gofal and IRIS are increasingly working together to link the two assessments. The IRIS team are beginning to learn how to use the STAR tool by shadowing Gofal staff and are interested in applying it for their clients in shared supported accommodation.

"What I wanted to do was to try to coincide visits between Gofal, IRIS and tenants so the three people are reviewing the recovery STAR together rather than Gofal doing it separately."

5.25 Practitioners were asked to reflect on the use of the tool from their own and client's perspectives. Gofal staff were very positive about the use of the tool (also drawing on their experience of using it on other projects) and IRIS staff were beginning to see the benefits although had more mixed feelings about its use. Little insight from service user perspective was gained from client interviews.

5.26 The tool is very visual, which allows clients to see their progress in a clear and easy to understand format. Staff and clients alike appear to find it straightforward to use and understand. The tool is quite flexible, and practitioners do adapt how they use it depending on the client, for example the level of detail used. As it is a client led tool it can be empowering for them to be able to map their own journey, assess their own needs and set their own goals. Most, although not all, clients are accepting of the use of the tool.

5.27 All practitioners felt that the tool has limitations. A key concern was that the nature of mental illness often means that clients lack insight into where they are on the STAR and what their needs and goals may be. This may be reflected in a complete refusal to engage with the tool. Some IRIS staff reflected that the tool cannot replace the skills of an experienced clinician or support worker to assess a client.

"One client told me 'that's for mentally ill people, I don't want that'…"

5.28 The initial STAR may show unrealistically high scores, which then drop in the second assessment as the client starts to develop some more insight and more trust and rapport with practitioners to enable more open and honest conversations. The changeable nature of mental illness may also have an impact on the effectiveness of the tool. Practitioners may mitigate this lack of insight by being mindful of the context in which the STAR is being scored and by "supportively challenging" the scoring. The nature of the STAR allows practitioners to focus the conversation around concrete examples. It does also allow them to gain insight into the level of insight clients do have and if necessary produce a 'shadow' STAR of their own which would mark the practitioner's assessment of the client.

"It does have its limitations, as any tool does, some people can score themselves unrealistically, sometimes we'd find that the first STAR you record with someone can be quite high, and then when it comes to the next one it can be lower and then they think they've regressed. But what that really means is that they've got to know us better as a support team and they feel more able to share really how they feel..."

Service-related outcomes

5.29 Although client outcomes are also service outcomes, service level outcomes are distinguished in this section as those that are related to the functioning of the service itself and display the elements of the service that need to be in place for the model to work and to potentially be expanded or replicated i.e. the factors for success.

5.30 The main service level outcome identified in the logic model is that the dispersed housing scheme working model should be a collaborative model for service delivery that leads to the pooling of expertise and the delivery of more streamlined and holistic support. Avoiding duplication is another key feature.

5.31 Other intermediate and long-term outcomes identified are client rehabilitation, reduction in service use, and successful maintenance of tenancy.

Collaboration

5.32 Gofal practitioners explicitly discussed the importance of collaborative working and maintaining strong and open dialogue between all practitioners to the success of such a model.

"Having that shared interest in that project is really different to the way I've worked in the past, because it's not just our project, it's not just their project, we've got a shared interest and it's all coming at it from an equal footing."

5.33 The joint assessment of a client at referral stage and the communication around the development of care and treatment plans supports the development of a person centred integrated care package and **crucially** seeks to ensure that there are no gaps in the service. It can be very difficult for one service alone to identify and address the complex needs of clients with high level needs. The collaboration allows a more streamlined approach to ensuring that needs do not go unmet, which could lead to break down in mental health and tenancies.

"…if we see any gaps anywhere then we will refer and get other agencies involved."
"…but you know if you've got CMHT visiting, and tenancy support visiting the communication isn't necessarily always there and quite often they work separately rather than together, whereas with this project it's more like one team, and it's more like a complete package around that person, so it's additional safeguards really."

5.34 This collaborative approach to developing the scheme is an on-going and evolving process and there has been a learning curve for all involved. At present IRIS work off the care and treatment plan that they develop and Gofal work on the areas identified in the client led

mental health recovery STAR. While there is considerable synergy between these plans they are not 'one plan'. Staff share the information with each other, and IRIS staff are starting to learn how to apply the STAR tool. The IRIS care plans, however, are held on the NHSs Paris data system[7], to which Gofal do not have access[8]. Inconsistent access to information can at times lead to duplication, misunderstanding and instances of mis-communication, despite all partners being willing and committed to sharing information to allow the service to function effectively. This is evidenced by the practical difficulties experienced by IRIS staff in managing the integration with Gofal in the Vale area.

"I suppose not as one team complete, because I think also the logistics of having separate offices and the PARIS system and stuff like that, access to it, and we haven't got access to what they're reporting. I think that's the biggest challenge in the communications side of it. Other communication wise we pick up the phone and that, but in terms of access to data and the logistics of being in a different office."

"That's been the difficult thing really because we've been used to doing everything across the board whatever help the person needs. Whereas they might be doing one thing and you might be doing another. When you go to a call and visit someone and they've helped the individual with someone in that respect and then the individual says they need some help with something they do. When people want help they usually want it now, and it's hard to say that's not my job that's someone else's job."

"Initially we were a bit like "oh ok, that's all a bit different to what we're used to", I think we both felt like that because the health board works very different from charities…"

[7] Paris is an integrated electronic patient record and case management system for monitoring and managing all aspects of community-based health and social care.

[8] Gofal can access a read only version of Paris at one of their Crisis houses, but day to day this is not practical for the Dispersed Housing Scheme.

5.35 The scheme is still new and teething problems and challenges are inevitable. All partners are committed to maintaining open and honest dialogue to address any issues and to improve working relationships and the service delivery. As one practitioner noted, one of the greatest challenges of working in collaboration is relinquishing autonomy, but it is necessary in order to achieve true collaboration.

"I think it's organisations who are willing to sacrifice some of their autonomy, you can talk about collaboration, but in reality collaboration only works if you're able to concede some control over your own service. I think both ourselves and the IRIS team have had to do that because no longer are we having to justify to our internal audience, we're having to reach shared decisions that both sides agree on, and those are things that you don't generally have to do."

5.36 All service practitioners are very positive about the development of the relationship and collaborative working, while at the same time acknowledging that it has been a steep learning curve and that there have been and continue to be issues that need to be addressed (see section ….for service improvements). They key theme that emerged from discussion about the relationship between practitioners was the importance of communication. The relationship has been developed through regular monthly meetings between all partners to monitor and improve service delivery. Some practitioners indicated that they would like to meet more frequently and be present at all monthly meetings to improve communication and avoid duplication. This may prove difficult due to the heavy case loads of practitioners.

"I know there have been some miscommunications between some of the staff and we've had to work on that. I think that's been productive because we've gained more understanding of our ways of working."
"But we're having meetings together now and we're starting to gel. I think we were pulling in different directions because we didn't know what our roles were, there were no defined roles really and perhaps we were overlapping too much. I think gradually its come together, as

we get to know each other and work together, yes I think it's definitely making leaps forward now, but initially there were a few hiccups…" We've learnt that with Gofal, the importance of communication, but we've got to make sure that's shared with all parts of the health service as well, the CMHT, in-patients when that's necessary.

Transition

5.37 There is strong recognition that the transition period for people with high level, enduring mental health needs is a crucial time and can be difficult. Transition and change are difficult for anyone, but for people with severe and enduring mental health conditions, the time-line of transition may be longer and the amount of support needed greater. The point of risk is often those transitions; leaving an acute setting the risks of relapse are greatest during the early period during the move from one setting to another. The dispersed housing model provides clients with both the time and the space needed to manage the risks inherent in this transition phase in a secure and supported manner, providing a smoother transition. In other service models the right amount of support at the right time often cannot be provided. The dispersed housing model seeks to fill this gap. The lack of hospital re-admissions due to relapse in mental health conditions provides some evidence that the scheme is successful in this aim.

"It's given people a much smoother route in the beginnings of their journey. I think just because of that they are then more confident to work in a more engaging manner and things are more positive because things have just fallen into place, or so it seems! Running around in the background! In that way it's been a real smooth transition for these people to come onto the scheme and to get working with them."

Time to develop rapport and trust

5.38 The lead-in time from initial assessment of a client to the beginning of their tenancy allows practitioners to work with clients before they take up their tenancy. This allows the clients to get to know as many staff

as possible and for a rapport to develop that can be built into trust. A number of practitioners identified this as a positive outcome. The amount of one on one time staff can spend with clients in privacy also helps to develop rapport and trust to build closer supporting relationships.

"So there's been a lot of work before the clients go into the houses to establish relationships, be that on the wards or wherever they're living at the time; and making sure that all the team are very much aware and building up the trust with that individual."

Appropriate accommodation in appropriate locations

5.39 The importance of securing appropriate accommodation in appropriate locations is highlighted as a key success factor for service delivery. It is important for the mental health of clients that they are provided with suitable properties away from negative influences and compounding factors, as all too frequently the clients have been housed in inappropriate accommodation that has broken down. In the past clients have had to take whatever is offered, irrespective of whether it is suitable or not. Ensuring that the properties are located in areas where they can maintain and strengthen family and friends networks and develop links in the local community is identified as very important. The property needs to be somewhere where the client can feel 'at home', somewhere where they would want to stay long-term.

"…we were going to be waiting and identifying properties in good areas where possibly people could have good support networks around them eventually…"

"So we felt quite strongly that we had to get people set up in a place where they were ultimately happy and would want to live for the long-term."

Client rehabilitation, reduction in service use, and successful maintenance of tenancy

5.40 The section on client outcomes (see 5.1) describes the extent to which current Dispersed Housing Scheme tenants have been rehabilitated. While this evaluation cannot show a causal link between the service provision and client outcomes the stories of individual clients, as reported by service practitioners, do provide some illustration of positive recovery. This evaluation cannot assess long-term outcomes, provide generalizable knowledge, nor show a causal link between the service provision and client outcomes. Individual client stories do provide some illustration of positive recovery.

5.41 As previously noted, there have been no re-admissions to hospital due to relapse in mental health conditions during the scheme so far. All tenants have successfully maintained their tenancies and are showing increased confidence in maintaining aspects of their tenancy such as managing benefits, reporting repairs and issues with neighbours.

5.42 There is one instance where a tenant has had some health problems that required hospitalisation. It is felt at present that this tenant is not using the flat in the way intended. More as an occasional respite space or space to socialise rather than a permanent home. Practitioners have expressed concern that this under utilisation is not being addressed and that there are no contingency plans in place to deal with such situations. Once a tenancy is agreed, it is their place (see section 5.45 on improvements to scheme). This is especially difficult due to the limited availability of one bedroom accommodation and the fact that one potential client has been waiting for a flat for over six months.

5.43 A long-term service level outcome is that the service is no longer required. Gofal and IRIS can then step down from providing a service and the client can either choose to maintain their tenancy themselves in the flat provided, or move on to a new home. This is the ultimate goal of the scheme.

5.44 Whilst none of the current tenants have moved on yet several clients have come a long way since entering the scheme and are showing signs of being able to step down from their current level of support soon and maintain their tenancy themselves. Time is needed to reach this stage, and the amount of time it takes for an individual to transition from one phase in their life to another varies considerably and is dependant on complex factors. While some may transition quite quickly others may always need a high level of support.
"I think because I'm making sure I'm taking my medication I am in a better place now, so in the long-term I'll be able to have less support and I'll be able to stand on my own two feet; like I'm doing already just with that little bit of added support at the moment is helping me along. But in the future yeah I think I'll be ok to be completely independent by myself."

Service improvements

5.45 Practitioners were asked to reflect on what improvements could be made to the scheme to further develop the service model. The main theme that emerged, which was also clear from discussions around the working relationship between the key delivery partners, was the need to improve communication. A number of suggestions were put forward:

- The need for more frequent communication. While the service managers attend monthly meetings, service practitioners felt there was merit in more frequent whole group meetings. A number of practitioners felt they would benefit from some team building exercises.
  "…to spend more time in meetings with the teams getting together, maybe team building…"

- A hub in the Vale. Neither IRIS nor Gofal have a base in the Vale despite spending a lot of time supporting clients in the Vale. This puts a strain on resources as staff travel around Cardiff and

the Vale without being able to make the most efficient use of their time. Practitioners suggested a Vale hub, which would provide a base for all dispersed housing scheme practitioners, enabling far better communication as they would cross paths more frequently, more efficient working and also a drop-in centre for the clients on the scheme as another level of the service.
"Having a shared office space, maybe working out of one area or being able to call at a base or a hub, because they haven't got anywhere at the moment, they're in Cardiff, IRIS are in Cardiff. Ironically we're providing a Vale service and neither of us are in the Vale."

- Cross-organisational use of the Paris system. The ease of communication would be greatly improved if all practitioners had access to read and update the Paris NHS data system that IRIS uses. Working towards achieving this has proved difficult, but there is a will to make this happen.
"I think ultimately communication would be vastly improved if we had access to PARIS, which is the health board's records system, that would make things so much easier because just simple things like knowing someone from the IRIS team has been out to visit someone that morning and was there any update, just flagging up things like that rather than relying on phonecalls, which sometimes is difficult because people are busy and in and out of the office. Just for any assessments that have been done, or updates in risk, having that regularly and us being able to enter notes onto PARIS."

5.46 The biggest challenge that the dispersed housing scheme has faced is the lack of suitable accommodation due to the scarcity of one bedroom flats since changes to housing benefits and bedroom tax legislation. This has meant that the wait for a property after assessment has often been longer than intended, which has risks to the stability of prospective clients. At the time of writing this report one client has been waiting over six months to move into a property. This

is a wider contextual factor that affects this scheme and may have implications for other similar initiatives.

5.47 A possible solution put forward is to find alternative ways of sourcing accommodation beyond just using one bedroom self-contained properties. This would involve using three or four bedroom shared accommodation as a stepping stone for a short period before moving on to their tenancy. Potentially this could improve the housing pathway and also provide an extra step in the journey of transition from acute care to independent living as an extra safety net to ensure suitability for the full independent living. This would be similar to the shared supported housing model serviced by the IRIS team in Cardiff, but the goal would be to move on after a short time, rather than stay on for an indefinite period. The team has also looked at using two bedroom flats as exemptions to the bedroom tax could be applied due to its supported housing status.

Service risks

5.48 These are identified as risks to the service and risks for clients. Practitioners were asked to identify these risks during interviews and some insight was received from client interviews.

Social-isolation

5.49 The main client risk identified was social isolation and loneliness due to the nature of living alone and not having built up strong networks due to long periods in institutionalised care. The service seeks to mitigate these risks by providing group activities that clients can join such as pool group, football group, breakfast club a service participation group, identification of social and community activities and group holidays, but there is acknowledgement that loneliness or isolation can occur. The effects of social isolation and loneliness can be exacerbated for people with high level mental health problems, particularly if they suffer from social anxiety, agoraphobia and paranoia, which can be a barrier to socialising.

"…in the flat there's nobody to tell, if they've done something or feel they've achieved something by going out and doing something on their own, there's nobody to come back and tell until a member of staff visits."

"I will be a bit lonely I suppose because I'm used to the support, but my friends have said they'll come down to see me, make sure I'm ok."

Substance abuse

5.50 Practitioners freely acknowledge that there are long periods of time when they are not with clients and that this means there is a risk that not only will some tenant needs not be picked up, but they may miss issues such as substance abuse.

"Because we're only there an hour a week...and what we learn and what we see and what they tell us and what we assess, it's still only a part, a little aspect of what is happening".

Dis-engagement

5.51 There is always a risk that the service will not provide the support needed due to dis-engagement on the part of the client. Not utilising the property was frequently highlighted as an issue, although it would appear that this is only a problem in one case. It was also highlighted that some clients may feel that the amount of support provided is 'too much' and can withdraw due to wanting more privacy. The nature of mental illness means that clients may lack insight into making the 'right' choices, which may mean receiving more support than they believe necessary.

"I think there is a possible opportunity where people can disengage easily, because they think oh now I've got my flat and everything's sorted I've got my benefits and I'm on my medication, I think there is a possibility that some people will be right that's it now, I'm done, I'm sorted. I think people forget that's not where their recovery stops,

they've got to keep working with us and tenancy support with Gofal, without setting aims and goals, they are quite easily disengaged".

Risk of tenancy failure

5.52 The logic model acknowledges that positive client and service outcomes may not be achieved due to the many variables in a person's mental health. The greatest risk to the success of the service is tenancy failure due to breakdown in mental health, for example a client experiences a life event that leads to a period of stress and breakdown in mental health. Whilst these occurrences can be damaging, the nature of the support offered by the Scheme and the increased confidence and resilience which accompanies independence, may reduce their impact. The failure in the tenancy would not be as a direct result of the service itself.

Risk management

5.53 While acknowledging the risks inherent in the service, and indeed in life, practitioners were clear that the purpose of the service they provide is to understand and to minimise risk through risk management and harm minimisation. The initial assessments are designed to identify potential risks and needs and to set up the support required to minimise risk. The promotion of positive risk taking is also seen as an important part of the scheme. Giving someone who may never have been given the chance before the opportunity to lay down roots in a safe way and supporting them to take positive risks. Practitioners also use harm minimisation techniques around, for example, the risk of using substances while taking medication for their mental health. The risk management is part of the safety net that the service provides.

"…we talked about that loneliness stuff- but if someone said 'oh I won't move there because I might feel lonely, you're denying them the opportunity of finding out what it's like to be lonely- but the positive risk is that someone might thrive, develop confidence and say 'well I

was lonely, but actually I coped for the last five days and it wasn't as bad as I thought it was going to be, now I'm ready to think about going to the library, the cinema with friends, the football…"

"There's always going to be risks in terms of managing people in the community and Supporting People's recovery within the community. I don't think you can ever rule out anything going wrong, but what's important is appropriate risk management. So their assessment, there are risk management plans, agreed ways of working and promoting positive risk taking, but in a safe and managed and appropriate way. So we wouldn't ever want to eradicate risk because that's how we develop, and that's how we grow but it's about enusuring people are able to take risks in a way that's safe. So it's allowing people a level of freedom and opportunity to see how things go."

"Is there more risk than any other discharges that we do with mental health? I'd say no. The important things is there is a triangulation of information from the in-patient ward, the IRIS team, from Gofal, so that we'r thinking about it, covering all bases with regards to risk, we've got other eyes on the patient to check, just in case we've missed something.

Sustainability and replication

5.54 Practitioners and stakeholders were asked to reflect on the sustainability of the scheme and whether they thought the service could be replicated in other areas and settings.

5.55 In general all were very positive about the future of the service and its sustainability. Practitioners and stakeholders believe in the importance and success of the project and are committed to improving the working model and providing a sustainable service.

"I do think it's sustainable, I do think it's a good pilot scheme, I think it's going to develop more, and we might see other projects that are following suit, hopefully."

"From a health point of view we believe that from our model and our staffing and services model we believe it is sustainable, evidence

based practice way of working. If for any reason our patners couldn't continue, we would be looking at other partners to engage with that and to see if we can make that work."

5.56 However practitioners and stakeholders alike were realistic about the challenges to sustainability and discussed a number of areas that could pose a threat.

Resources

5.57 A number of stakeholders and practitioners pointed to the availability of resources as a potential stumbling block to future sustainability. The scheme is currently reliant on funding from the Welsh Government's Supporting People fund so commissioning cycles and the availability of funds must be taken into account. The continuation of funding on the NHS side is also crucial. However both the NHS and Gofal are committed to looking at alternative funding sources.

"It's sustainable so long as there's a Supporting People budget and there's an NHS budget. We've configured the service so that it washes its face financially, we can't pre-empt what changes that may come down the line with future austerity and funding cuts, but at the moment I would like to think that the service is viable, sustainable and replicable elsewhere."

5.58 At present the IRIS team are stretched in terms of staffing levels and are being asked to deliver an increasing amount of services. The continuation and the expansion of the scheme will rely on sufficient people to staff it.

"……by broadening the scheme obviously we're going to need more resources, we're going to need more staff……Sometimes we're just so busy it's difficult."

5.59 Currently, the greatest threat to the continued sustainability of the scheme is the availability of suitable one bedroom accommodation. This issue has clear consequences for the service being able to continue to offer clients their own accommodation. The end goal of the service for each client is for them to receive less support over time

until they no longer require support. They can then either stay in their flat or move to another tenancy. At present no tenant has moved on or indicated that they wish to do so. If nobody moves on, new accommodation will need to be found, which could prove very difficult in the current climate.

"Obviously the sustainability of the project in terms of how many properties we require..."

The need to look at other service models

5.60 The sustainability of the scheme may require investigating the delivery of support through adapted service models. For example, the limited availability of one bedroom accommodation may necessitate a move towards support being provided within two or three bedroomed accommodation. This would also address the concern that some clients may not be quite ready for full independence by providing an extra step in the journey of transition from acute care to independent living.

Unpredictability of demand

5.61 Several practitioners highlighted that the unpredictability of demand could be an issue for sustainability. At present the scheme cannot be too widely promoted as the service is running at capacity, but in order to expand, awareness must be raised. The logic model discussion raised the fluctuating nature of demand and the paucity of accurate data on client need; practitioner interviews underlined how difficult demand is to predict.

"……you'd have a certain number of people and then it seems to stop...that's what happened in Pen yr Ynys- we've rehabilitated everybody, there's no more people coming through for rehabilitation, we've exhausted that, there's no more need for this project and then it stopped...I was in a meeting the other day and the in-patient rehabilitation areas in Cardiff have got a waiting list and I was thinking, well they're from the Vale, they're from the Vale...just when you think that there's no more need, there is! It's never constant, it's

peaks and troughs."

Replication

5.62 Practitioners and stakeholders were positive about whether the scheme could be replicated in other areas or in other settings. While recognising that the dispersed housing scheme is a pilot and the service continues to evolve there is scope for expanding and replicating the model. The discussion of service level outcomes and sustainability provide a platform for the factors that need to be considered were this model to be replicated.

"I do actually because I think that housing associations have a much greater role to play in terms of working with the health board, NHS, bed blocking and I think we're in a sector where we're very underutilised and there's lots of potential there for collaborative working."

"I think it's got to be the way forward, especially within the financial climate. Also ethically to our clients we have a huge duty as well within mental health services, not everybody believes this, but I do, we have got a duty to make sure that people are integrated effectively within their communities, with their friends, with their families, their neighbours, with their employers, with their teachers, we have to integrate into the community, into society. That's the only way we're going to overcome the barriers that people with mental health problems face on the daily basis, the stigma, the prejudice that does exist within the community, is by engaging effectively with people in the community. So I would say that dispersed housing model is a way of doing that, its part of that."

5.63 The Context-Mechanisms-Outcomes configuration of the ICE-F model (see figure 1) can be used to reflect on the findings of this Research. The context for the DHS Service model is discussed in section 2 . This and the development of the logic model, as well as the evidence collected during the research clearly show that a shared understanding of the challenges faced and a collaborative and

integrated approach to addressing the problem were key features of the operating environment that have been conducive to achieving positive outcomes. The mechanisms of delivering the DHS are a combination of established professional expertise and new ways of working as a result of collaboration and integration. The DHS is a coherent intervention with a strong logic behind how it intends to achieve its outcomes. In terms of replicating this service model many of the mechanisms used could be replicated elsewhere in other areas or contexts. The evidence from this evaluation highlights the importance of the contextual factors in which an intervention is conceived as this will influence the mechanisms used for delivery and the outcomes achieved.

Wider awareness of the dispersed housing scheme

5.64 Several practitioners noted that from their experience there was often a lack of awareness of housing and mental health support services for people for whom a step down from acute care is appropriate within the institutions providing acute care. Practitioners generally felt that awareness of the dispersed housing scheme amongst other health professionals was quite low. This is in part due to a lack of publicisation to ensure that demand does not exceed supply. However, when practitioners have raised awareness of the scheme there has been strong interest from the mental health care and housing professions, particularly when Gofal have talked about the scheme.

"…but whether there should be people at the CMHT meetings because people don't recognise that [dispersed housing scheme] could be a good option, even when they're aware of the project , they seem to say they're full, or there's a waiting list, or we'll go for a quicker fix."

"…there seems to be a great deal of interest in it, some of the dialogue we have about similar projects maybe to a different client group is informed by the dispersed approach…"

Risk management

5.65 While acknowledging the risks inherent in the service, and indeed in life, practitioners were clear that the purpose of the service they provide is to understand and to minimise risk through risk management and harm minimisation. The initial assessments are designed to identify potential risks and needs and to set up the support required to minimise risk. The promotion of positive risk taking is also seen as an important part of the scheme. Giving someone who may never have been given the chance before the opportunity to lay down roots in a safe way and supporting them to take positive risks. Practitioners also use harm minimisation techniques around, for example, the risk of using substances while taking medication for their mental health. The risk management is part of the safety net that the service provides.

"…we talked about that loneliness stuff- but if someone said 'oh I won't move there because I might feel lonely, you're denying them the opportunity of finding out what it's like to be lonely- but the positive risk is that someone might thrive, develop confidence and say 'well I was lonely, but actually I coped for the last five days and it wasn't as bad as I thought it was going to be, now I'm ready to think about going to the library, the cinema with friends, the football…"

"There's always going to be risks in terms of managing people in the community and Supporting People's recovery within the community. I don't think you can ever rule out anything going wrong, but what's important is appropriate risk management. So their assessment, there are risk management plans, agreed ways of working and promoting positive risk taking, but in a safe and managed and appropriate way. So we wouldn't ever want to eradicate risk because that's how we develop, and that's how we grow but it's about enusuring people are able to take risks in a way that's safe. So it's allowing people a level of freedom and opportunity to see how things go."

"Is there more risk than any other discharges that we do with mental health? I'd say no. The important things is there is a triangulation of

information from the in-patient ward, the IRIS team, from Gofal, so that we're thinking about it, covering all bases with regards to risk, we've got other eyes on the patient to check, just in case we've missed something.

6. Recommendations

6.1 The recommendations are based on the research undertaken for the purposes of this evaluation and cover three key areas:

Recommendations for the Welsh Government and other public service organisations.

6.2 Whilst initial outcomes are promising, further testing of this service and other similar 'floating support' models are needed to assess the longer-term outcomes of integrated approaches, for both the service and service users. Public service organisations, alongside those delivering services should investigate other service delivery models and funding models for this and other potenital housing and mental health support that may provide similar benefits to the Dispersed Housing Scheme.

6.3 Public service organisations should consider the application of this working model to other settings and locations where individuals with high level needs could benefit from person-centred, integrated care e.g. alcohol and substance misuse.

Recommendations for the Vale of Glamorgan Dispersed Housing Scheme

6.4 Whilst some measurement data for the DHS are collected through Supporting People returns, the Recovery STAR and Care and Treatment Plans there is scope for more systematic collection of validated, integrated and consistent service outcome indicators.

6.5 Assessing true levels of need for the service provided by the DHS has proved difficult. If the service is to grow, and be replicated elsewhere a more strategic approach to needs assessment and service promotion should be considered.

6.6 Developing a Hub – a shared office space/drop-in centre – in the Vale would improve service efficiency (staff would have an office space near clients so would not have to travel back to Cardiff as frequently) and improve communication between Gofal and IRIS staff (as they

would physically be in the same space). A Hub could also act as a place for clients to go and to socialise in the community.

6.7 The DHS should put in place robust contingency plans for underutilisation of tenancy.

6.8 There is clearly a need for all service practitioners to have access to the Paris system in order to improve communication and avoid duplication. The DHS should continute to press for a solution to achieve access to the system. Alternatively other data sharing platforms may be considered.

Recommendations for future evaluations of integrated health and social care delivery

6.9 Further evaluation of the DHS and similar models of integrated health and social care delivery should consider the use of the Integrated Care Evaluation Framework in their design.

6.10 Further evaluation of the DHS and similar models of integrated health and social care delivery should include economic evaluation in order to assess the cost effectivness of this model of delivery.

6.11 In order to strengthen the evaluation of the impact of integrated models of mental health and housing service delivery a set of validated, consistent outcome measure indicators should be developed. These should include both service and service user outcome indicators.

6.12 The management information collected and monitoring systems for this and future similar models of service delivery should be designed with the evaluation of the service in mind. The collection of baseline data is a key part of evaluating changes over time.

6.13 While recognising that the service user's voice is a critical part of an evaluation of user led services, future evaluations should consider carefully the appropriate methodological approach and resources necessary to collect robust data.

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